National Kidney Foundation®

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August 24, 2017

Seema Verma
Administrator
Centers for Medicare and Medicaid Services
Room 314G
Hubert H. Humphrey Building,
200 Independence Avenue, SW
Washington, DC 20201

RE: CMS-1674-P: Medicare Program; End-Stage Renal Disease Prospective Payment System, Payment for Renal Dialysis Services Furnished to Individuals With Acute Kidney Injury, and End-Stage Renal Disease Quality Incentive Program

Dear Administrator Verma:

The National Kidney Foundation appreciates the opportunity to comment on the proposed changes to the end-stage renal disease (ESRD) prospective payment system (PPS), including policies that will govern coverage and payment for renal dialysis services delivered to individuals with acute kidney injury (AKI), and the quality incentive program (QIP) for payment years 2019-2021. The National Kidney Foundation is the largest, most comprehensive and longstanding, patient centric organization dedicated to the awareness, prevention and treatment of kidney disease in the US. In addition, the National Kidney Foundation has provided evidence-based clinical practice guidelines for all stages of chronic kidney disease (CKD), including transplantation since 1997 through the National Kidney Foundation Kidney Disease Outcomes Quality Initiative (KDOQI).

I. Proposed Changes to the 2018 ESRD PPS

a. Patient and Facility Payment Adjusters

The National Kidney Foundation appreciates CMS commitment to ensuring patient access to high quality dialysis care. We recognize that a sustainable Medicare payment policy is paramount to ensuring access to treatment, particularly given that

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81% of all ESRD patients are Medicare Fee for Service Beneficiaries (FFS).[1] We also appreciate CMS intent to ensure that the PPS adjusts for patients who may be costlier to care for. However, the National Kidney Foundation is concerned the outlier payments, patient case mix adjusters, and low volume and rural facility adjusters are not accurately accounting for higher cost patients.

i. **Outlier Payments**
We appreciate CMS proposing to modify the outlier payment threshold amounts to try and ensure that the 1% of total payments reserved is paid back out to facilities that have patients with higher than usual medication costs. However, we are concerned that each year the actual disbursement of outlier payments never reaches the 1%. Since outlier payments are taken from the base rate this results in money being withheld and never returned that should have gone into paying for patients' care. The National Kidney Foundation strongly supports CMS having an outlier payment policy as we believe this is a helpful policy to ensuring that costlier patients receive the care they need. However, we recommend that CMS revisit the calculation and application of this payment policy to ensure that total amount of payments withheld are paid back to facilities for patient care.

ii. **Patient Case Mix Adjusters**
While no changes to the case mix adjusters were proposed this year, The National Kidney Foundation remains concerned that the patient adjusters do not serve the intended policy purpose to protect high cost patients from the risk of under-treatment or impaired access to care. Specifically, the base age range of 70-79 is inappropriate as facilities would not receive a payment adjustment for this age group, but would increase payments by 7% for the 60-69 group. Clinician opinion is that older age is correlated with higher risks of falls and malnutrition requiring extra attention and care during dialysis treatments. The National Kidney Foundation also questions the rationale for CMS's use of both a body surface area (BSA) and body mass index (BMI) adjustment and encourage the agency to use only a BMI adjustment for overweight and underweight patients to better account for costs of treatment, including additional attentiveness by clinicians, longer treatment

[1] United States Renal Data System. 2016 USRDS annual data report: Epidemiology of kidney disease in the United States. National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases, Bethesda, MD, 2016.

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times, and increased medication needs. It appears that the cost reports as the data source for these adjusters are not reliable or reflecting the patient characteristics that clinicians believe are actual drivers of higher costs. As a result, payments are not reflecting the policy intent of these adjusters and we recommend that CMS quickly work with clinicians to revise the patient adjusters to ensure they serve their purpose of accounting for higher cost patients.

iii. **Low Volume/Rural Adjuster**
The National Kidney Foundation remains concerned that even with the addition of a rural facility adjuster there continues to be an existing incentive for facilities within close approximation to one another to limit access to their facility in order to meet the requirements for the low volume adjuster. This unnecessarily increases healthcare costs, including co-pays for patients, and does not serve the policy intent of ensuring the viability of dialysis facilities to serve in areas where there is a sparse patient population. In addition, as facilities serve AKI patients, some could be at risk of losing the low-volume facility adjuster even when dialyzing these patients temporarily. We encourage CMS to revisit the rural and low-volume adjusters by convening stakeholders in the kidney community to discuss solutions to protect patient access to care in a cost-effective manner.

b. **Transitional Drug Add-On Payment Adjuster**
The National Kidney Foundation appreciates that CMS has now issued guidance as to when and how the new calcimimetic etelcalcetide and the oral calcimimetic cinacalcet will be included in the ESRD program. Since these medications will be the first to be paid under the new Transitional Drug Add-On Payment Adjuster (TDAPA) we request CMS closely monitor the effect it has on patient access to the therapies and outcomes. Specifically, for calcimimetics CMS should monitor claims to see if there are any changes in parathyroidectomies during TDAPA and after the add-on payment has ended. Historically, moving medications into the PPS has been thought to account for lower utilization, which may affect clinical outcomes. It will be important to monitor whether there are any changes to patient outcomes as a result of this new policy.

The National Kidney Foundation supports the TDAPA policy. However, we have previously requested that TDAPA be implemented without beneficiary cost sharing in order to ensure patients have access to new medications. Given that if the TDAPA

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policy had not been applied, these medications would have immediately been part of the PPS and patients would not pay a separate 20% coinsurance for them. Patients should not have to bear the burden of an additional coinsurance, particularly when it may cost some patients more than it otherwise would have under their Part D plan. We believe that it is within CMS authority to waive this cost-sharing as TDAPA is part of the ESRD PPS and is an additive payment to dialysis facilities.

The National Kidney Foundation also remains concerned that TDAPA does not go far enough to encourage innovation in the care of ESRD patients. Specifically, innovation is discouraged within the functional categories because generally TDAPA would not apply if a new drug was developed to treat conditions that fall into those categories. This hinders any incentive for companies to develop new medications that may have fewer side effects or be more effective in improving outcomes within those functional categories. While we recognize it would not be appropriate or cost effective for every new drug to be paid for under TDAPA we do encourage CMS to allow more flexibility in the process to allow for innovation.

c. Home Dialysis for ESRD Patients

While not addressed in this rule, CMS had previously stated that it would review cost reports to better understand the costs of home dialysis training. We inquire about CMS's progress towards this goal. We also continue to be concerned about the inconsistency in paying for extra dialysis treatments for home patients even when medical justification is provided. Denying payment when medical justification is provided can be a barrier to increasing home dialysis use.

The National Kidney Foundation strongly supports more patients using home therapies and we are pleased that CMS has longstanding support for this as well. A strong training program is key to ensuring patients and their care partners feel confident to conduct treatments at home. Home dialysis is an important treatment option that allows patients greater flexibility in how and when they do their dialysis without compromising clinical outcomes. It is critical that CMS and Medicare Administrative Contractors; payment policies consistently cover the costs of training and more frequent treatments in order to remove barriers to home dialysis.

d. Proposed AKI payment

The National Kidney Foundation is supportive of AKI patients having the opportunity receive dialysis in outpatient dialysis clinics and for Medicare to reimburse those dialysis facilities for the treatment of AKI. AKI patients requiring dialysis are a

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distinctly different clinical population from ESRD and the ultimate goal of their treatment is to restore kidney function. Delivering evidence based treatment is more difficult in this population due to the lack of evidence available. The KDIGO guidelines and KDOQI commentary provide recommended best practices for treating this population, but many of the recommendation statements are not graded and represent consensus clinical judgement. This underscores the need for treatments to be individualized. For those reasons, we support the CMS proposal to adjust the base rate for AKI only by the geographic and wage indices. However, we also recognize than in limited cases, particularly for rural patients, peritoneal dialysis (PD) can be a helpful option for treatment. While AKI patients need frequent labs and monitoring, some patients can safely do dialysis at home and have labs drawn in a location closer to the patient's home. In these circumstances, we recommend that home training be paid for separately, without dollars removed from the base rate.

While a distinct population, regulations intended to ensure appropriate staffing and care delivery in dialysis facilities should also address the care of AKI patients. NKF recommends that CMS update the conditions of coverage to account for this new patient population. However, not all CfCs will need to apply to AKI patients. Specifically, requirements about the delivery of modality options information and evaluation for vascular access placement are not necessary requirements for this population. Additionally, care planning for AKI patients is more likely to be necessary on a weekly basis rather than a monthly basis and Kt/V targets will be different than for ESRD patients.

Additionally, CMS agreed to closely monitor the AKI population – a goal NKF supports as monitoring can provide data and information on outcomes, percentage of patients that transition to ESRD, timing of AKI to ESRD diagnosis, and care practices for this population. We request that CMS share the details of its monitoring policy for AKI patients and the data collected on these patients publicly.

e. Advancing Health Information Technology

The National Kidney Foundation remains concerned about the lack of information sharing between hospitals and dialysis facilities. CMS should require hospitals to share discharge summaries with the patient's nephrologist or dialysis facility, when they are known to the hospital, within 48 hours. There is evidence that an additional nephrology visit and early intervention following a hospital admission could reduce

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the risk of readmissions.[2, 3] Proper care coordination with patients' nephrologists and dialysis facilities can also help hospitals avoid readmissions within 30 days of discharge.

II. ESRD QIP

a. Quality measures for AKI patients

Given that AKI patients are clinically different from those with ESRD the quality measures that apply to ESRD patients should not apply to AKI patients. As we mentioned previously, it is reasonable to expect most patients to be diagnosed with ESRD after 90 days on dialysis, but there are instances where patients may recover renal function beyond the 90 days. However, CMS should monitor whether there is any unintended incentive to increase the length of time patients are diagnosed as AKI instead of ESRD.

The National Kidney Foundation believes that quality measures should be developed and used to ensure that patients with AKI receive high quality care and achieve the best possible clinical outcomes. However, we do not think the QIP should apply to AKI patients. The AKI payment and quality program must be administered separately from the ESRD PPS and QIP. Additionally, if CMS is to collect measure reporting data for AKI patients via CROWNWeb, the system should be modified to ensure that data on AKI patients is separate from those of ESRD patients.

To establish a quality program for AKI patients, we believe measures should initially be for reporting only. While the KDOQI/KDIGO guidelines were updated in 2012 many of the guideline statements were not graded because there is a lack of randomized control trial evidence to support them. A potential starting place for measure development in AKI could be a weekly Kt/V target of 3.9 when intermittent or extended dialysis is used as this has highest level of evidence with a KDIGO guideline grade of 1A.[4]

The National Kidney Foundation also recommends including a measure for avoidance of blood stream infections. AKI patients will most likely receive dialysis

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[2] Erickson, Kevin F., et al. Physician Visits and 30-Day Hospital Readmissions in Patients Receiving Hemodialysis, JASN, 25: 2014.

[3] Chan, Kevin E. Association between repeat hospitalization and early intervention in dialysis patients following hospital discharge, Kidney International (2009) 76, 331–341.

[4] Palevsky, Paul, et al., KDOQI US Commentary on the 2012 KDIGO Clinical Practice Guideline for Acute Kidney Injury, Am J Kidney Dis. 61(5):649-672

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with a catheter making them more susceptible to infections. CMS should also seek to develop patient reported outcomes measures for this population, including assessments of patient satisfaction. However, we note the CAHPs survey process as it currently is for ESRD patients would not be appropriate because most AKI patients will not be receiving dialysis in the facility for a full year.

b. Accounting for Social Risk Factors

The National Kidney Foundation is supportive of evaluating the impact that social risk factors have on dialysis facility performance of certain measures in the QIP. Interestingly we note that as the Office of the Assistant Secretary for Planning and Evaluation's (ASPE) 2016 report on Social Risk Factors Performance Under Medicare's Value Based Purchasing Programs found that among facilities serving a high proportion of patients with social risk factors such as high dual, disability, or African American populations were more likely to receive penalties under the QIP, while facilities having a high portion of Hispanic populations, patients residing in low income areas or rural areas were less likely to receive penalties. However, as ASPE notes new measures added to the QIP such as the standardized readmission, standardized transfusion and standardized hospitalization measures could show greater variation in performance on those measures and on the QIP scores. We offer some recommendations and consideration as CMS explores how to account for social risk factors in measures used within the QIP and Dialysis Facility Compare (DFC) Star Ratings.

i. Stratifying performance reporting, for each dialysis facility, on clinical quality measures by social risk factors known to influence performance on the measures may help illuminate disparities in outcomes within a dialysis facility. This allows facilities to identify the impact social risk factors have on measure development and to develop strategies to improve outcomes in those groups and close any gaps they may have within the facility. Stratifying reporting on performance to highlight differences in performance between dialysis facilities based on the proportion of patients served may highlight facilities that need greater support to improve outcomes for their patients. CMS should provide support through quality improvement activities to help facilities with lower quality performance and high proportions of patients with social risk factors. The ESRD Networks would be well positioned to work with facilities on these projects. We agree with the ASPE report that such evaluation of new quality measures in the QIP should be evaluated for the impact social risk factors have on performance, but we can't recommend

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adjustment at this time due to the potential unintended consequence of masking poor performance and because we believe risk adjustment may discourage additional effort to address improvement where feasible.

ii. Since the QIP is a penalty based program the National Kidney Foundation is concerned that as new measures are brought into the QIP where social risk factors impact performance this could discourage facilities from admitting patients with social risk factors and could also discourage opening or maintaining facilities in areas where patients with these risk factors reside. As a result of this concern we suggest CMS consider a reward based incentive for facilities that improve outcomes in populations with social risk factors. This would help to drive resources towards facilities that serve a high number of patients with social risk factors and encourage innovative solutions to reducing disparities. Should a reward based program not be effective in closing gaps on certain measures then reconsideration of adjusting certain measures for social risk factors may be appropriate.

iii. While the ASPE report highlighted duals status as the strongest predictor of disparate outcomes we question why this might be as many individuals with dual Medicare and Medicaid coverage have access to social services that patients who fall just outside of eligibility for Medicaid may not. For example, in many states Medicaid beneficiaries have coverage for transportation. Also, those who are eligible for Medicaid are likely eligible for other community programs to include nutritional programs. Instead, we suggest it is likely a combination of underlying social risk factors that lead to the duals population being the greatest risk predictor. To better illuminate which factors are driving differential performance and thus allow for more targeted interventions, we suggest CMS may need to evaluate additional data points on social risk factors such as mental health status and income ranges.

iv. The QIP is a penalty program and while few facilities currently receive penalties – additional outcomes based measures that have been added to the program may illuminate challenges in reaching targets due to serving a high proportion of patients with social risk factors. Facilities should be encouraged and rewarded for developing creative solutions to address disparities and improve outcomes.

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c. Proposed changes to the Performance Score Certificate (PCS)

The National Kidney Foundation does not support modifying the PCS to only reflect the total performance score. We believe this removes transparency and leads to greater potential for misunderstanding about the quality of care a dialysis facility provides. The National Kidney Foundation does appreciate CMS's intent to provide quality of care information to patients in a more understandable manner. We strongly agree that providing patients and families with clear information, taking into account principles of health literacy, about the quality of care delivered in individual dialysis facilities is of utmost importance. Current efforts fall substantially short of this goal, but we do not agree that limiting the availability of information is the right approach.

Instead, we recommend that CMS work with kidney patients to redesign the PCS in a manner that meaningfully and understandably communicates the QIP results to patients. The National Kidney Foundation is happy to offer the assistance of our health education experts and our professional and patient volunteers to assist in this project.

In addition, we note that based on a survey of dialysis patients administered by the National Kidney Foundation that most patients are unaware of the PCS or understand what the information means. Despite mandatory requirements that the PCS be posted where patients can see it and that staff in the facility be able to explain it to patients, according to the National Kidney Foundation's survey of patients, only 32% of patients say they have ever seen the PCS and of those patients about 41% stated they understood what the information meant. Taking away information from the PCS will only lead to less understanding of its meaning.

We also believe that the difference between the QIP score and the Dialysis Facility Compare (DFC) Star Ratings in publicly reporting quality is problematic and confusing. Having two different approaches to grading and publicly communicating dialysis facility quality on similar measure sets undermines the goal of helping patients understand the quality of care delivered in a dialysis facility. We continue to encourage CMS to pursue a strategy for either basing the DFC Star Ratings on performance in the QIP or substantially differentiating DFC Star Ratings by assigning stars based on the quality information that patients value most and or using consumer driven ratings. The National Kidney Foundation has conducted patient surveys on this topic and have shared the results with CMS and its contractors. We would be happy to further discuss the results and work with CMS to improve public

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reporting of dialysis facility quality.

d. Policy for Weighting the Clinical Measure Domain for PY 2020

The National Kidney Foundation continues to have concerns with the finalized policy to maintain both the NHSN Dialysis Event Reporting Measure and the NHSN bloodstream infection (BSI) in hemodialysis, clinical measure. We urge CMS to fix the underlying challenges with the NHSN BSI clinical measure to ensure its validity and to institute a system where hospitals are required to report BSI either directly to NHSN or directly to dialysis facilities so they can appropriately report on the measures. We do not believe that including a reporting measure within the patient safety domain will solve the underlying challenge of receiving information on BSIs from hospitals and only dilutes the value of a BSI measure.

e. Proposed Measures for the PY 2021 ESRD QIP

The National Kidney Foundation supports the change in the Vascular Access Type measures in the QIP. The new measures align with our recommendations to address the small number of patients for whom a catheter may be the most appropriate vascular access when life expectancy is limited.

We also recommend that CMS clarify in the numerator for the fistula measure that a catheter is not present. The presence of a catheter increases the risk for infection even if it is not in use. Related, we recommend that the catheter measure include in the numerator all patients with a catheter in place for the reporting period, whether the hemodialysis catheter is in continuous use or not.

f. Proposed Revision of the Standardized Transfusion Ratio (STrR) PY 2021

The National Kidney Foundation believes anemia is an important clinical and quality of life outcome for patients. While we appreciate CMS has reviewed and made some modifications to address NQF concerns on this measure, the National Kidney Foundation does agree with the Measures Application Partnership that further refinement of the measure to stratify and appropriately capture blood transfusions that could have been prevented by the dialysis facility and exclude transfusions that result for acute or chronic medical conditions outside the scope of practice of the facility. For example, sickle cell anemia and anemia caused by hematologic malignancies should be excluded.

We remain concerned that a StR alone does not completely counter-act the potential to under-treat anemia and sets a low bar for an outcome measure. The KDOQI

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Anemia Management guidelines recommend a target hemoglobin of 9.0 g/dl -10.0 g/dl. In addition, a transfusion avoidance measure does not consider patients' quality of life or the cardiovascular risks associated with low hemoglobin levels. The National Kidney Foundation encourages CMS to pursue other clinical measures to better address the anemia in dialysis patients.

g. Continuing Measures for PY 2021

Regarding the remaining measures in the QIP we remind CMS on our recommendations for improving these in the following table.

Continuing Measures 2021	NKF Recommendations
In-Center Hemodialysis CAHPS Survey	NKF believes it is important for dialysis patients, who spend a considerable amount of their time in the dialysis facility, to be satisfied with the attention and time they receive from the facility staff and to feel safe and comfortable in their surroundings. We remain concerned with the length of the survey and the frequency it is administered. If only a few questions from the survey are to be used in the QIP perhaps it would not be unreasonable to shorten the survey to focus on those items or to administer the survey in two parts.
Standardized Readmission Ratio	NKF supports the measure, but remains concerned about the effect of the measure on patient access to care. NKF looks forward to the results of the study CMS has planned on evaluating the effect this measure has on patient access to care. We also request that CMS remove any overlap between this measure and the Standardized Hospitalization Ratio that would penalize facilities twice.
Standardized Hospitalization Ratio	NKF supports holding dialysis facilities accountable for preventing hospitalizations that are actionable by the nephrology care team. We do raise concern that there may be overlap with the Standardized Readmissions Ratio (SRR), which would cause readmissions that occur within the 30-day window of an index hospitalization to be counted in both this measure and the SRR thereby penalizing facilities twice. NKF does not believe this is appropriate and encourages CMS to correct this in the measure specifications before the measurement year.

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Kt/V Dialysis Adequacy Comprehensive Measure	NKF continues to oppose the use of a pooled dialysis adequacy measurement and encourages CMS to return to the individual adequacy measures or construct a composite measure where each individual measure is evaluated and then rolled up to one score. In last year's final rule CMS stated each individual measure and population was evaluated, however the measure as specified lumps the entire population of patients, including pediatrics, adult PD patients, and hemodialysis patients receiving four or less treatments per week into one denominator with a single score calculated for the measure. As the National Quality Forum (NQF) renal standing committee pointed out the evidence for the Kt/V targets for the hemodialysis population is based on three times per week dialysis not four. NKF also disagrees with CMS's assertion in last year's final rule that including the pediatric population into a pooled measure is more beneficial than having a separate measure. The pooled measure does not accomplish the goal of ensuring pediatric patients receive adequate dialysis as the measure does not allow for evaluating this patient population separately from the adult population.
Hypercalcemia	. While the National Kidney Foundation understands that CMS is required by The Protecting Access to Medicare Act of 2014 (PAMA) to include quality measures related to conditions that are treated with oral only medications, NKF recommends removing hypercalcemia as a clinical measure and instead using it as a reporting measure. While hypercalcemia is potentially an important modifiable marker associated with mortality,this measure is unlikely to drive additional improvements in outcomes,. Therefore, we believe reverting it to a reporting measure is the most feasible approach to fulfilling the requirements of PAMA while ensuring the QIP more highly values measures that drive improvement in patient outcomes.
Serum Phosphorus Reporting	The National Kidney Foundation continues to believe a composite measure that includes hypercalcemia, intact-PTH and phosphorus is the most meaningful way to evaluate bone and mineral metabolism.
Anemia Management Reporting	We appreciate that CMS continues to monitor hemoglobin levels and encourage the agency to clinical measure that promotes optimal hemoglobin targets

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Ultrafiltration Reporting Measure	The National Kidney Foundation does not see the value in a reporting measure of ultrafiltration, particularly when there is an NQF endorsed clinical measure that if implemented would be more meaningful to patient outcomes. We encourage CMS to implement the NQF# 2701: Avoidance of Utilization of High Ultrafiltration Rate (>/= 13 ml/kg/hour), which has been supported for endorsement by the NQF renal standing committee. The KDOQI hemodialysis adequacy clinical practice guidelines, do not include a target for UFR and instead recommend minimizing UFR as best possible in order to maximize hemodynamic stability and tolerability of the hemodialysis procedure. This is because the supporting evidence for a specific target is limited.[5] One retrospective study (not cited in the evidence for this measure) suggests an increased risk for individuals with heart failure with a UFR between 10-14 ml/h/kg, but improvements in outcomes for individuals without heart failure with a UFR in that range.[6] While this remains an area of active investigation and debate with the recognition that prospective randomized clinical trials are needed to more clearly define an appropriate target, NKF supports using the NQF #2701 in the QIP. However, we note implementing the measure is not without challenges that will require efforts from dialysis providers, dialysis facility staff, physicians and patients to overcome. Successfully meeting the measure will require patient participation and adherence to the dialysis prescription and fluid restrictions. The KCQA measure includes a total treatment time greater than 240 minutes which excludes patients that dialyze for less time than the average patient to better recognize the individual patient needs and desires.
Pain Assessment and Follow up	It is important for a properly trained health care worker (we recommend a technician, nurse, or physician or advanced practitioner) to ask at every treatment whether the patient is experiencing pain, to have the patient rate their pain, and for the nurse, physician, or advanced practitioner to try and assess the root cause. We further agree that the pain, its source, and

[5] National Kidney Foundation. KDOQI clinical practice guideline for hemodialysis adequacy: 2015 update. *Am J Kidney Dis*. 2015;66(5):884-930.
[6] Flythe, Jennifer E., et al. Rapid Fluid Removal During Dialysis is Associated With Cardiovascular Morbidity and Mortality. Kidney Int. 2011;79(2):250-257.

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	recommended treatment be documented in the patients care plan and that a referral to a specialist be made when appropriate.
Clinical Depression Screening and Follow-Up	The National Kidney Foundation encourages CMS to modify the depression screening measure to require that the same methodology for detecting depression be used across dialysis facilities, or at a minimum require that the methodology for how depression was detected be reported. Dialysis facility social workers are equipped and trained to employ strategies to improve symptoms of depression by providing education and counseling. However, persistent or severe depression needs to be referred to a mental health practitioner for further diagnosis and treatment. This measure must not hold the dialysis facility or nephrologist accountable for counseling or prescribing anti-depressant medications to patients, since these are both outside the scope of practice of nephrologists. Therefore, we encourage CMS to include in the measure documentation of appropriate referral to treatment for persistent depression that cannot be addressed by social support provided by dialysis facility social workers.

III. Request for Information on Medicare Flexibilities and Efficiencies

The National Kidney Foundation appreciates the opportunity to comment on ways CMS can foster improvements in patient-centered care and to ensure that patients can make the best choices possible. Specifically, we want to highlight the confusion that having two, distinct public reporting programs on dialysis facility quality that rely on the same quality measures poses to patients. To make the best choices about their care, dialysis patients and their loved ones should have the opportunity to identify and understand the quality of care delivered in their current dialysis facilities and among dialysis facilities they may seek to receive care at before starting dialysis or when traveling. However, the two programs used to publicly report quality, the Quality Incentive Program, which is also used for facility payment adjustment, and the Dialysis Facility Compare (DFC) Star Rating programs overlap in the measures they use to reflect quality performance ratings and each program uses a different methodology and different mechanism to calculate and display performance on these quality measures. This is at best confusing and at worst misleading to patients and families. The National Kidney Foundation recommends that either 1) the QIP performance be used to assign star ratings or 2) the DFC Star

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Ratings be completely redesigned to reflect quality of care indicators that matter most to patients and/or be an anonymous consumer powered rating system.

The National Kidney Foundation appreciates that CMS staff has engaged Technical Expert Panels (TEP) to improve the DFC start ratings website and has included the National Kidney Foundation in that process. We were pleased with CMS's willingness to change the methodology used to assign star ratings away from hard cut points that required a certain percentage of facilities to fall into each rating category (e.g., 1-star 10% 2-star 20%, 3-star 30%, 4-star 20%, and 5-star 10%). We also appreciate that CMS continues to engage patients in improvements to the program. However, the first DFC TEP report also reflected that the measures used for DFC star ratings do not reflect the factors most important to patients (i.e. cleanliness, safety, attentiveness of clinicians). Despite comments from the patient community advocating for redesign, continued TEPs to improve the program have focused on incremental improvements. The National Kidney Foundation has submitted data to CMS and its contractors on quality indicators that patients and families view as most important and on the usefulness of DFC in determining where patients receive dialysis. We would be pleased to work with CMS to inform redesigning its public quality reporting programs so that they are more helpful tools for patients to make decisions about their care.

The National Kidney Foundation greatly appreciates the opportunity to submit our comments on this proposed rule.

Sincerely,

Kevin Longino *Michael Choi*

Kevin Longino
CEO
Kidney Transplant Recipient

Michael Choi, MD
President